

Medicaid Freedom of Choice (FOC) List

For Waiver Services

PROVIDER REQUEST

Please Check One:

New FOC Request

Update existing FOC information

Notification of Agency Closure or Service Termination: Enter Effective Date:

Please Print/Type ALL Information Requested:

Current Information	Previous Information
Provider Name:	Former Name:
Provider Address(Include City, State, Zip):	Former Address:
Provider Contact Name &	Former Provider Contact Name &
Provider Phone - Fax Number(s) (Include area code): Phone : Fax:	Previous Provider Phone - Fax Number(s) (Include area code): Phone: Fax:
Provider Toll-Free Phone Number:	Former Provider Toll Free Phone Number:
Provider E-Mail	Former Provider E-Mail

Please place/update/remove the above named agency on/from the Freedom of Choice list for the provider type(s) checked below.

<input type="checkbox"/>	03	Children's Choice (Children's Choice Waiver)	Region(s):	
<input type="checkbox"/>	06	Professional Services [NOW] Check all applicable services: <input type="checkbox"/> Psychologist <input type="checkbox"/> Social Worker <input type="checkbox"/> Nutritional/Dietary	Region(s):	
<input type="checkbox"/>	11	Shared Living (ROW)	Region(s):	
<input type="checkbox"/>	13	Pre Vocational	Region(s):	
<input type="checkbox"/>	14	Day Habilitation	Region(s):	
<input type="checkbox"/>	15	Environmental Modifications	Region(s):	
<input type="checkbox"/>	16	Personal Emergency Response System (PERS)	Region(s):	
<input type="checkbox"/>	17	Medical Equipment and Supplies (Assistive Devices)	Region(s):	
<input type="checkbox"/>	31	Psychologist (ROW)	Region(s):	
<input type="checkbox"/>	35	Physical Therapist (ROW)	Region(s):	
<input type="checkbox"/>	37	Occupational Therapist (ROW)	Region(s):	
<input type="checkbox"/>	39	Speech Therapist (ROW)	Region(s):	
<input type="checkbox"/>	41	Registered Dietician (ROW)	Region(s):	
<input type="checkbox"/>	44	Skilled Nursing (NOW)	Region(s):	
<input type="checkbox"/>	73	Social Worker (ROW)	Region(s):	
<input type="checkbox"/>	82	Personal Care Attendant (PCA): <input type="checkbox"/> CC/NOW/SW <input type="checkbox"/> ROW Check one if ROW is selected above: <input type="checkbox"/> Community Living Supports <input type="checkbox"/> Companion Care Support <input type="checkbox"/> Both CLS and CCS	Region(s):	
<input type="checkbox"/>	83	Center-Based Respite	Region(s):	
<input type="checkbox"/>	84	Substitute Family Care: <input type="checkbox"/> NOW <input type="checkbox"/> ROW	Region(s):	
<input type="checkbox"/>	85	ROW Adult Day Health Care (ADHC)	Region(s):	
<input type="checkbox"/>	89	Supervised Independent Living (SIL) – (NOW)	Region(s):	
<input type="checkbox"/>	98	Supported Employment	Region(s):	

Provider's Signature and Title:

Date:

It is the **Provider's Responsibility** to notify the Louisiana Department of Health (LDH), Waiver Supports and Services, regarding any changes in the above noted information within ten (10) days of any changes. To keep from being removed from the FOC list, a provider's license and enrollment must be kept current. This notice will **NOT** notify Molina Provider Enrollment or Licensing regarding these changes.

The following must be included with all submissions:

Completed FOC Form, 2.) A **copy** of your current license, and 3.) A **copy** of you Medicaid Provider Enrollment Letter(s)

Mail or Fax to:

OCDD/Waiver Supports & Services

628 North 4th Street, 2nd Floor

Baton Rouge, LA 70802

Fax: (225) 342-8823

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